Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

AUSTIN TX 78731

Requestor Name and Address

RICHARD SEXTON MD
5209 TORTUNGA TRAIL

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-13-0985-01

MFDR Date Received
DECEMBER 17, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I saw the above claimant on 6/29/12 in my capacity as a designated doctor, to address the issue of extent of injury only. The bill for service was denied, with the EOR stating simply: 'Based on extent of injury.' Since the exam was set for me to determine that very issue, the stated reason for denial was nonsensical. A bill resubmission was made on 11/16/12. I received a second EOR, with payment again denied. This time, however, the EOR did not state a reason for the denial. In summary, I performed a Division-ordered DDE to determine extent of injury. Although I submitted the report along with a complete and correct bill to the carrier in a timely manner, payment has not been twice denied in violation of the state fee schedule guidelines."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier or its agent did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2012	Division Ordered Designated Doctor Exam	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for Workers' Compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 219 – Based on extent of injury.

Issues

1. Did the insurance carrier reimburse according to the fee guideline?

2. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §134.204(i): The following shall apply to Designated Doctor Examinations. (1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W6." The requestor has supported his position that this was a Commissioner ordered Designated Doctor Examination for the purpose of determining the extent of the employee's compensable injury. Therefore, the insurance carrier's denial of 219 - "Based on extent of injury." is not supported.
2. In accordance with 28 Texas Administrative Code §134.204(k): The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee. The requestor has submitted sufficient documentation to support reimbursement.

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Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Marguerite Foster	March 28, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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